

Ophthalmology, PC
300 N. Grandview Ave.
Dubuque, IA 52001-6397
Phone: (563) 588-4675
Fax: (877) 241-4588

Bryan P. Pechous, MD
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Authorization for Release of Confidential Health Information

Patient Name: _____ Birth Date: _____
Address: _____
Phone#: _____ Cell#: _____

Authorizes:

Name of Medical Office	Phone Number	Fax Number	
Address of Medical Office	City	State	Zip

To Disclose To: Ophthalmology, PC
300 N. Grandview Ave.
Dubuque, IA 52001
Fax: (877)241-4588

All Medical Records from the last 3 years
 Other: _____

Reason for Release: Transferring Care Moving out of area 2nd Opinion Personal File
 Coordination of Care Other: _____

*****My appointment is scheduled:** _____

I do NOT want any of the following information released:

Mental health treatment records Drug abuse treatment records
 Alcoholism treatment records HIV/Acquired immunodeficiency syndrome (AIDS) records

- I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event that I refuse to authorize the release of the above described information. I understand that it will not be disclosed, except as provided by law.
- I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information to a third party.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.
- I understand that I may revoke this authorization at any time by giving written notice to my physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where my physician has already replied on it to use or disclose my health information. Written revocation must be sent to our office.
- This authorization for release of information will be valid for 1 year but only for medical information that was available on or before the date that this authorization was signed. A new, separate authorization will be required for release after the date this authorization was signed.

Signature of Patient or Legal Guardian

Date

Relationship to Patient (Parent, Guardian, Power of Attorney, etc.) _____